IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
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BUREAU OF FACILITY STANDARDS
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March 22, 2010

SusanBroetje, Administrator
Idaho State School And Hospital
1660 Eleventh Avenue North
Nampa, ID 83687

RE: Idaho State School And Hospital, Provider #13G001

Dear Ms. Broetje:

This is to advise you of the findings of the Medicaid/Licensure Fire Life Safety Survey, which was concluded at Idaho State School And Hospital, on March 16, 2010.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice;

2. How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;

3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;

4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **April 5, 2010**, and keep a copy for your records.

Thank you for the courtesies extended to us during our visit. If you have any questions, please call or write this office at (208) 334-6626.

Sincerely,

TAYLOR BARKLEY
Health Facility Surveyor
Fire Life Safety & Construction Program

TB/lj

Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 01 B. WING _____	03/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS The "Redwood Building" was originally constructed in 1967 and is a single story structure with a mechanical room in the basement. The building's original construction classification is protected non-combustible. The building is protected by an automatic sprinkler system and a complete supervised fire alarm/smoke detection system with off site monitoring. There are a total of two exits to grade from the central core plus each of the four pods containing resident sleeping rooms have a door to grade and a door to the central core. Emergency power is provided by an on site generator and battery powered emergency lighting units are installed. The following deficiencies were cited during the annual Fire/Life Safety survey conducted between March 9, 2010 and March 16, 2010. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, CH 19 Existing Health Care Occupancy and in accordance with 42 CFR 483.70. The surveyor conducting the fire/life safety survey was: Taylor Barkley Health Facility Surveyor Facility Fire Safety and Construction Program	K 000	RECEIVED APR 0 1 2010 FACILITY STANDARDS	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

SBroetje 3/30/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	Continued From page 1	K 000		
K 018	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This Standard is not met as evidenced by: Based on observation the facility did not ensure that corridors are separated by smoke resisting partitions and doors. The facility had a census of sixty eight clients on the day of the survey.	K 018		

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K 018	Continued From page 2 Findings include: During the tour of the facility on March 9, 2010 at 9:35 AM, observation of the door to the laundry room revealed a transfer grill in the lower half of the door. This was observed by the Surveyor and the Maintenance Supervisor. This deficiency has the potential to affect fifteen clients and all staff present on the day of the survey. Actual Code Reference NFPA 101 - 2000 Edition Chapter 19 Existing Healthcare Occupancies 19.3.6.4 Transfer Grilles. Transfer grilles, regardless of whether they are protected by fusible link-operated dampers, shall not be used in these walls or doors.	K 018		4-13-10 TB
K 046	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This Standard is not met as evidenced by: Based on record review, it was determined the facility had not ensured emergency lighting was being tested monthly or annually. The facility had a census of sixty eight clients on the day of the survey. Findings include: During record review on March 10, 2010 at 11:07 AM, maintenance records revealed the facility did not have records for either monthly or annual	K 046		

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K 046	Continued From page 3 testing of the emergency lighting units throughout the facility. This was noted by the Surveyor and the Maintenance Supervisor. This deficiency has the potential to affect fifteen clients and all staff present on the day of the survey. Actual Code Reference NFPA 101 - 2000 Edition Chapter 19 Existing Healthcare Occupancies 19.2.9 Emergency Lighting. 19.2.9.1 Emergency lighting shall be provided in accordance with Section 7.9. 7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 11/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction.	K 046		4-30-10

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K 047	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 This Standard is not met as evidenced by: Based on observation the facility did not ensure that exit signs were continuously illuminated. The facility had a census of sixty eight clients on the day of the survey. Findings include: During the tour of the facility on March 9, 2010 at 9:50 AM, observation of two exit signs in one pod of the Redwood building revealed that they were not illuminated. This was observed by the Surveyor and the Maintenance Supervisor. This deficiency has the potential to affect fifteen clients and all staff present on the day of the survey. Actual Code Reference NFPA 101 - 2000 Edition Chapter 19 Existing Healthcare Occupancies 19.2.10.1 Means of egress shall have signs in accordance with Section 7.10. 7.10.5.2* Continuous Illumination. Every sign required to be illuminated by 7.10.6.3 and 7.10.7 shall be continuously illuminated as required under the provisions of Section 7.8.	K 047		4-30-10 TB
K 062	NFPA 101 LIFE SAFETY CODE STANDARD	K 062		

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K 062	Continued From page 5 Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This Standard is not met as evidenced by: Based on record review, the facility failed to inspect and test the automatic sprinkler system as required. The facility had a census of sixty eight clients on the day of the survey. Findings include: Record review on March 10, 2010 between the hours of 10:10 AM and 11:20 AM, revealed that the facility was unable to provide documentation of any quarterly inspections or tests of the automatic sprinkler system. This was noted by the Surveyor and the Maintenance Supervisor. This deficiency has the potential to affect fifteen clients and all staff present on the day of the survey. Actual Code Reference NFPA 101 - 2000 Edition Chapter 19 Existing Healthcare Occupancies 19.3.5 Extinguishment Requirements. 19.3.5.1 Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. 9.7.5 Maintenance and Testing. All automatic sprinkler and standpipe systems required by this Code shall be inspected, tested, and maintained in accordance with NFPA 25,	K 062		4-30-10 TB

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K 062	Continued From page 6 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25 2-1 General. This chapter provides the minimum requirements for the routine inspection, testing, and maintenance of sprinkler systems. Table 2-1 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance. Table 2-1 Summary of Sprinkler System Inspection, Testing, and Maintenance Quarterly testing for Alarm Devices and Main Drain.	K 062		
K 064	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This Standard is not met as evidenced by: Based on observation the facility did not ensure that portable fire extinguishers were being checked on a monthly basis. The facility had a census of sixty eight clients on the day of the	K 064		4-30-10 TB

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K 064	Continued From page 7 survey. Findings include: During the tour of the facility on March 9, 2010 between the hours of 9:30 AM and 9:50 AM, observation of the portable fire extinguishers revealed that they were not being checked on a monthly basis or being signed off on the affixed tag. This was observed by the Surveyor and the Maintenance Supervisor. This deficiency has the potential to affect fifteen clients and all staff present on the day of the survey. Actual Code Reference NFPA 101 - 2000 Edition Chapter 19 Existing Healthcare Occupancies 19.3.5.6 Portable fire extinguishers shall be provided in all health care occupancies in accordance with 9.7.4.1. 9.7.4.1 Where required by the provisions of another section of this Code, portable fire extinguishers shall be installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. NFPA 10 4-3 Inspection. 4-3.1* Frequency. Fire extinguishers shall be inspected when initially placed in service and thereafter at approximately 30-day intervals. Fire extinguishers shall be inspected at more frequent intervals when circumstances require.	K 064		

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K 064	Continued From page 8	K 064		
K 144	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This Standard is not met as evidenced by: Based on record review, it was determined the facility had not ensured that the emergency generator was being inspected weekly or load tested monthly in accordance with NFPA 99. The facility had a census of sixty eight clients on the day of the survey. The findings include: Record review of the generator log on March 10, 2010 at 11:20 AM, disclosed that the facility did not document weekly checks or monthly load tests on the emergency generator. This was noted by the Surveyor and the Maintenance Supervisor. This deficiency has the potential to affect fifteen clients and all staff present on the day of the survey. Actual NFPA standard: NFPA 99 1999 edition 3-4.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches.	K 144		4-30-10 TB

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K 144	Continued From page 9 (a) Maintenance of Alternate Power Source. The generator set or other alternate power source and associated equipment, including all appurtenant parts, shall be so maintained as to be capable of supplying service within the shortest time practicable and within the 10-second interval specified in 3-4.1.1.8 and 3-4.3.1. Maintenance shall be performed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems NFPA 110 1999 edition 6-4.1 Level 1 and Level 2 EPSSs, including all appurtenant components, shall be inspected weekly and shall be exercised under load at least monthly.	K 144		

TAG #: K-018, MM309

1. Corrective action for the identified problem.
A work order to cover up the grill in the Redwood CSU has been issued.

2. Discipline responsible for monitoring system changes for maintenance of compliance.
- ***Maintenance***
- ***M&O Supervisor***

3. Date when correction action will be corrected (usually within 60 days):

April 30, 2009 10 TB

TAG #: K-046, MM309

1. Corrective action for the identified problem.
The testing on the emergency lighting for the Redwood CSU had been completed monthly but the testing log was included with the monthly generator test log (see attached).

3. Discipline responsible for monitoring system changes for maintenance of compliance.
- ***Electrician***
- ***M&O Supervisor***

3. Date when correction action will be corrected (usually within 60 days):

Done

TAG #: K-047, MM309

1. Corrective action for the identified problem.
The Redwood CSU's exit signs have been repaired. A monthly check will be scheduled to ensure compliance is maintained.

4. Discipline responsible for monitoring system changes for maintenance of compliance.
- ***Maintenance Craftsman Senior***
- ***M&O Supervisor***

3. Date when correction action will be corrected (usually within 60 days):

April 30, 2010

TAG #: K-062, MM309

1. Corrective action for the identified problem.
The Redwood CSU sprinkler system has been inspected and tested. A quarterly schedule will be developed to ensure that compliance is maintained.

5. Discipline responsible for monitoring system changes for maintenance of compliance.
- ***Electrician***
- ***M&O Supervisor***

3. Date when correction action will be corrected (usually within 60 days):

April 30, 2010

TAG #: K-064, MM309

1. Corrective action for the identified problem.
The Redwood CSU's fire extinguishers have been checked and a monthly schedule will be developed.

6. Discipline responsible for monitoring system changes for maintenance of compliance.
- ***Maintenance***
- ***M&O Supervisor***

3. Date when correction action will be corrected (usually within 60 days):

April 30, 2010

TAG #: K-144, MM309

1. Corrective action for the identified problem.
Weekly inspections for the Redwood CSU building generator have been initiated and a schedule will be developed to ensure compliance is maintained.

7. Discipline responsible for monitoring system changes for maintenance of compliance.
- ***Electrician***
- ***M&O Supervisor***

3. Date when correction action will be corrected (usually within 60 days):

April 30, 2010

Bureau of Facility Standards

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M 000	16.03.11 Inital Comments The "Redwood Building" was originally constructed in 1967 and is a single story structure with a mechanical room in the basement. The building's original construction classification is protected non-combustible. The building is protected by an automatic sprinkler system and a complete supervised fire alarm/smoke detection system with off site monitoring. There are a total of two exits to grade from the central core plus each of the four pods containing resident sleeping rooms have a door to grade and a door to the central core. Emergency power is provided by an on site generator and battery powered emergency lighting units are installed. The following deficiencies were cited during the annual Fire/Life Safety survey conducted between March 9, 2010 and March 16, 2010. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, CH 19 Existing Health Care Occupancy and in accordance with IDAPA 16.03.11 - Rules Governing Intermediate Care Facilities For The Mentally Retarded	M 000	RECEIVED APR 0 1 2010 FACILITY STANDARDS	

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M 000	Continued From Page 1 (ICF/MR) The surveyor conducting the fire/life safety survey was: Taylor Barkley Health Facility Surveyor Facility Fire Safety and Construction Program	M 000		
MM309	16.03.11.110 Fire and Life Safety Standards Buildings on the premises used as facilities must meet all the requirements of local, state and national codes concerning fire and life safety standards that are applicable to ICF/MR facilities. This Rule is not met as evidenced by: Refer to federal deficiencies listed on the CMS 2567 form. 1. K018 Transfer Grills 2. K046 Testing of Emergency Lighting. 3. K047 Exit Signs Not Illuminated 4. K062 Quarterly Sprinkler Inspections 5. K064 Monthly Checks Of Fire Extinguishers 6. K144 Generator Inspections and Checks	MM309	See Poc on CMS 2567	4-30-10 TB

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 000	INITIAL COMMENTS The medical building is a single story structure of protected wood frame construction. The original building was constructed in 1963 and the "E" wing addition in 1977. The building is protected throughout by a complete automatic fire extinguishing system and an upgraded fire alarm/smoke detection system. Multiple exits to grade serve the building , plus there are direct exits to grade from several "suits" within the building. Emergency power is supplied by two on-site, fuel fired, automatic generators; one serving the original building and the other serves the 1977 addition. Wings "B" and "C" are separated from the remainder of the building by two hour rated wall assemblies. The following deficiencies were cited during the annual Fire/Life Safety survey conducted between March 9, 2010 and March 16, 2010. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, CH 19 Existing Health Care Occupancy and in accordance with 42 CFR 483.70. The surveyor conducting the fire/life safety survey was: Taylor Barkley Health Facility Surveyor Facility Fire Safety and Construction Program	K 000	RECEIVED APR 01 2010 FACILITY STANDARDS	

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SBroetje 3/30/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 02 B. WING _____	03/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1	K 000		
K 018	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This Standard is not met as evidenced by: Based on observation the facility did not ensure that corridors are separated by smoke resisting	K 018		4-30-10 TB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 02 B. WING _____	03/16/2010

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K 018	Continued From page 2 partitions and doors. The facility had a census of sixty eight clients on the day of the survey. Findings include: 1. During the tour of the facility on March 9, 2010 between the hours of 9:55 AM and 10:43 AM, observation of the following doors revealed transfer grills in the lower half of the doors. The doors observed are as follows; 822, A14, A42, A52, A55, D11, D12, D17 and the Temperature Control Room. This was observed by the Surveyor and the Maintenance Supervisor. This deficiency has the potential to affect eleven clients and all staff present on the day of the survey. 2. During the tour of the facility on March 9, 2010 between the hours of 9:57 AM and 9:58 AM, observation of the following doors revealed that they are dutch doors without a Rabbet , Astragal, or Bevel. The doors observed are as follows; the door to the Music Room and the door to the Kitchen. This was observed by the Surveyor and the Maintenance Supervisor. This deficiency has the potential to affect eleven clients and all staff present on the day of the survey. Actual Code Reference NFPA 101 - 2000 Edition Chapter 19 Existing Healthcare Occupancies 19.3.6.4 Transfer Grilles. Transfer grilles, regardless of whether they are protected by fusible link-operated dampers, shall not be used in these walls or doors. 19.3.6.3.6 Dutch doors shall be permitted where they conform to 19.3.6.3. In addition, both the upper leaf and lower leaf shall be equipped with a latching device, and the meeting edges of the	K 018		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 018	Continued From page 3 upper and lower leaves shall be equipped with an astragal, a rabbet, or a bevel.	K 018		
K 046	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This Standard is not met as evidenced by: Based on record review, it was determined the facility had not ensured emergency lighting was being tested monthly or annually. The facility had a census of sixty eight clients on the day of the survey. Findings include: During record review on March 10, 2010 at 11:08 AM, maintenance records revealed the facility did not have records for either monthly or annual testing of the emergency lighting units throughout the facility. This was noted by the Surveyor and the Maintenance Supervisor. This deficiency has the potential to affect eleven clients and all staff present on the day of the survey. Actual Code Reference NFPA 101 - 2000 Edition Chapter 19 Existing Healthcare Occupancies 19.2.9 Emergency Lighting. 19.2.9.1 Emergency lighting shall be provided in accordance with Section 7.9. 7.9.3 Periodic Testing of Emergency Lighting Equipment.	K 046		4-30-10 TB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 046	Continued From page 4 A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 11/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction.	K 046		
K 062	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This Standard is not met as evidenced by: Based on record review, the facility failed to inspect and test the automatic sprinkler system as required. The facility had a census of sixty	K 062		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 062	Continued From page 5 eight clients on the day of the survey. Findings include: Record review on March 10, 2010 between the hours of 10:10 AM and 11:20 AM, revealed that the facility was unable to provide documentation of any quarterly inspections or tests of the automatic sprinkler system. This was noted by the Surveyor and the Maintenance Supervisor. This deficiency has the potential to affect eleven clients and all staff present on the day of the survey. Actual Code Reference NFPA 101 - 2000 Edition Chapter 19 Existing Healthcare Occupancies 19.3.5 Extinguishment Requirements. 19.3.5.1 Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. 9.7.5 Maintenance and Testing. All automatic sprinkler and standpipe systems required by this Code shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25 2-1 General. This chapter provides the minimum requirements for the routine inspection, testing, and maintenance of sprinkler systems. Table 2-1 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance. Table 2-1 Summary of Sprinkler System	K 062		4-30-10 TB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 062	Continued From page 6 Inspection, Testing, and Maintenance Quarterly testing for Alarm Devices and Main Drain.	K 062		
K 064	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This Standard is not met as evidenced by: Based on observation the facility did not ensure that portable fire extinguishers were being checked on a monthly basis. The facility had a census of sixty eight clients on the day of the survey. Findings include: During the tour of the facility on March 9, 2010 between the hours of 9:55 AM and 10:45 AM, observation of the portable fire extinguishers revealed that they were not being checked on a monthly basis or being signed off on the affixed tag. This was observed by the Surveyor and the Maintenance Supervisor. This deficiency has the potential to affect eleven clients and all staff present on the day of the survey.	K 064		4-30-10 JB

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K 064	Continued From page 7 Actual Code Reference NFPA 101 - 2000 Edition Chapter 19 Existing Healthcare Occupancies 19.3.5.6 Portable fire extinguishers shall be provided in all health care occupancies in accordance with 9.7.4.1. 9.7.4.1 Where required by the provisions of another section of this Code, portable fire extinguishers shall be installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. NFPA 10 4-3 Inspection. 4-3.1* Frequency. Fire extinguishers shall be inspected when initially placed in service and thereafter at approximately 30-day intervals. Fire extinguishers shall be inspected at more frequent intervals when circumstances require.	K 064		
K 144	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144		4-30-10 TB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 144	Continued From page 8 This Standard is not met as evidenced by: Based on observation and record review it was determined the facility had not ensured that the emergency generator was being inspected or was installed in accordance with NFPA 99. The facility had a census of sixty eight clients on the day of the survey. The findings include: 1. Record review of the generator log on March 10, 2010 at 12:35 PM, disclosed that the facility did not document weekly checks on the emergency generator. This was noted by the Surveyor and the Maintenance Supervisor. This deficiency has the potential to affect eleven clients and all staff present on the day of the survey. 2. During the tour of the facility on March 9, 2010 at 10:35 AM, observation of the E-Wing generator room revealed that there was not an emergency light installed in the room for the generator. This was observed by the Surveyor and the Maintenance Supervisor. This deficiency has the potential to affect eleven clients and all staff present on the day of the survey. Actual NFPA standard: NFPA 99 1999 edition 3-4.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches. (a) Maintenance of Alternate Power Source. The generator set or other alternate power source and associated equipment, including all appurtenant	K 144		

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K 144	Continued From page 9 parts, shall be so maintained as to be capable of supplying service within the shortest time practicable and within the 10-second interval specified in 3-4.1.1.8 and 3-4.3.1. Maintenance shall be performed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems NFPA 110 1999 edition 5-3 Lighting. 5-3.1 The Level 1 or Level 2 EPS equipment location shall be provided with battery-powered emergency lighting. The emergency lighting charging system and the normal service room lighting shall be supplied from the load side of the transfer switch. 6-4.1 Level 1 and Level 2 EPSSs, including all appurtenant components, shall be inspected weekly and shall be exercised under load at least monthly.	K 144		

TAG #: K-018, MM309

1. Corrective action for the identified problem.
All transfer grills will be covered. The Dutch doors to the music room and kitchen will be modified to ensure the gap has a smoke seal.

2. Discipline responsible for monitoring system changes for maintenance of compliance.
- ***Maintenance Craftsman Senior***
- ***M&O Supervisor***

3. Date when correction action will be corrected (usually within 60 days):

April 30, 2010

TAG #: K-046, MM309

1. Corrective action for the identified problem.
The testing on the emergency lighting for the Medical building had been completed monthly but the testing log was included with the monthly generator test log (see attached).

3. Discipline responsible for monitoring system changes for maintenance of compliance.
- ***Electrician***
- ***M&O Supervisor***

3. Date when correction action will be corrected (usually within 60 days):

Done

TAG #: K-062, MM309

1. Corrective action for the identified problem.
The Medical building sprinkler system has been inspected and tested. A quarterly schedule will be developed to ensure that compliance is maintained.

4. Discipline responsible for monitoring system changes for maintenance of compliance.
- ***Plumber***
- ***M&O Supervisor***

3. Date when correction action will be corrected (usually within 60 days):

April 30, 2010

TAG #: K-064, MM309

1. Corrective action for the identified problem.
The fire extinguishers have been checked and a monthly schedule will be developed.

5. Discipline responsible for monitoring system changes for maintenance of compliance.
- ***Maintenance***
- ***M&O Supervisor***

3. Date when correction action will be corrected (usually within 60 days):

April 30, 2010

TAG #: K-144, MM309

1. Corrective action for the identified problem.
A work order has been assigned to the electrician to install an emergency light in the generator room in the Medical building.

6. Discipline responsible for monitoring system changes for maintenance of compliance.
- ***Electrician***
- ***M&O Supervisor***

3. Date when correction action will be corrected (usually within 60 days):

April 30, 2010

TAG #: K-144, MM309

1. Corrective action for the identified problem.
A schedule for weekly generator checks will be initiated to ensure compliance is maintained.

7. Discipline responsible for monitoring system changes for maintenance of compliance.
- ***Electrician***
- ***M&O Supervisor***

3. Date when correction action will be corrected (usually within 60 days):

April 30, 2010

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 02 B. WING _____	03/16/2010

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IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

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M 000	16.03.11 Inital Comments The medical building is a single story structure of protected wood frame construction. The original building was constructed in 1963 and the "E" wing addition in 1977. The building is protected throughout by a complete automatic fire extinguishing system and an upgraded fire alarm/smoke detection system. Multiple exits to grade serve the building , plus there are direct exits to grade from several "suits" within the building. Emergency power is supplied by two on-site, fuel fired, automatic generators; one serving the original building and the other serves the 1977 addition. Wings "B" and "C" are separated from the remainder of the building by two hour rated wall assemblies. The following deficiencies were cited during the annual Fire/Life Safety survey conducted between March 9, 2010 and March 16, 2010. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, CH 19 Existing Health Care Occupancy and in accordance with IDAPA 16.03.11 - Rules Governing Intermediate Care Facilities For The Mentally Retarded (ICF/MR)	M 000	RECEIVED APR 8 1 2010 FACILITY STANDARDS	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

SBuetje 3/30/10

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 02 B. WING _____	03/16/2010

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M 000	Continued From Page 1 The surveyor conducting the fire/life safety survey was: Taylor Barkley Health Facility Surveyor Facility Fire Safety and Construction Program	M 000		
MM309	16.03.11.110 Fire and Life Safety Standards Buildings on the premises used as facilities must meet all the requirements of local, state and national codes concerning fire and life safety standards that are applicable to ICF/MR facilities. This Rule is not met as evidenced by: Refer to federal deficiencies listed on the CMS 2567 form. 1. K018 Transfer Grills and Dutch Doors 2. K046 Testing of Emergency Lighting. 3. K062 Quarterly Sprinkler Inspections 4. K064 Monthly Checks Of Fire Extinguishers 5. K144 Generator Weekly Checks and no Emergency Light in Generator Room	MM309	See POC on CMS 2567	4-30-10 ZB

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 000	INITIAL COMMENTS	K 000		

The "Aspen" building is a single story structure, with a mechanical loft, that was completed /occupied in December 2002. The building's construction classification is Type V(III) protected wood frame. The building is protected throughout by an automatic fire extinguishing system and a fire alarm/smoke detection system. Emergency power is supplied by an on site, fuel fired, automatic generator as well as battery pack emergency lighting. The building consists of a central core and two wings with sleeping rooms. There is a total of six exits to grade, two in each of the wings containing resident sleeping rooms and two from the central core. The building is divided into three smoke zones by two smoke barrier partition walls. The building has 20 ICF/MR beds.

The following deficiencies were cited during the annual Fire/Life Safety survey conducted between March 9, 2010 and March 16, 2010. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, CH 19 Existing Health Care Occupancy and in accordance with 42 CFR 483.70.

The surveyor conducting the fire/life safety survey was:

Taylor Barkley
Health Facility Surveyor
Facility Fire Safety and Construction Program

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

SBroetje 3/30/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	Continued From page 1	K 000		
K 046	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This Standard is not met as evidenced by: Based on record review, it was determined the facility had not ensured emergency lighting was being tested monthly or annually. The facility had a census of sixty eight clients on the day of the survey. Findings include: During record review on March 10, 2010 at 11:10 AM, maintenance records revealed the facility did not have records for either monthly or annual testing of the emergency lighting units throughout the facility. This was noted by the Surveyor and the Maintenance Supervisor. This deficiency has the potential to affect fourteen clients and all staff present on the day of the survey.	K 046		4-30-10 TB

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K 046	Continued From page 2 Actual Code Reference NFPA 101 - 2000 Edition Chapter 19 Existing Healthcare Occupancies 19.2.9 Emergency Lighting. 19.2.9.1 Emergency lighting shall be provided in accordance with Section 7.9. 7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 11/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction.	K 046		
K 062	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5	K 062		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 062	Continued From page 3 This Standard is not met as evidenced by: Based on record review, the facility failed to inspect and test the automatic sprinkler system as required. The facility had a census of sixty eight clients on the day of the survey. Findings include: Record review on March 10, 2010 between the hours of 10:10 AM and 11:20 AM, revealed that the facility was unable to provide documentation of any quarterly inspections or tests of the automatic sprinkler system. This was noted by the Surveyor and the Maintenance Supervisor. This deficiency has the potential to affect fourteen clients and all staff present on the day of the survey. Actual Code Reference NFPA 101 - 2000 Edition Chapter 19 Existing Healthcare Occupancies 19.3.5 Extinguishment Requirements. 19.3.5.1 Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. 9.7.5 Maintenance and Testing. All automatic sprinkler and standpipe systems required by this Code shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems.	K 062		4-30-10 TB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 03 B. WING _____	03/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 062	Continued From page 4 NFPA 25 2-1 General. This chapter provides the minimum requirements for the routine inspection, testing, and maintenance of sprinkler systems. Table 2-1 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance. Table 2-1 Summary of Sprinkler System Inspection, Testing, and Maintenance Quarterly testing for Alarm Devices and Main Drain.	K 062		
K 144	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This Standard is not met as evidenced by: Based on record review, it was determined the facility had not ensured that the emergency generator was being inspected weekly in accordance with NFPA 99. The facility had a	K 144		4-30-10 TB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 03 B. WING _____	03/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 144	Continued From page 5 census of sixty eight clients on the day of the survey. The findings include: Record review of the generator log on March 10, 2010 at 12:39 PM, disclosed that the facility did not document weekly checks on the emergency generator. This was noted by the Surveyor and the Maintenance Supervisor. This deficiency has the potential to affect fourteen clients and all staff present on the day of the survey. Actual NFPA standard: NFPA 99 1999 edition 3-4.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches. (a) Maintenance of Alternate Power Source. The generator set or other alternate power source and associated equipment, including all appurtenant parts, shall be so maintained as to be capable of supplying service within the shortest time practicable and within the 10-second interval specified in 3-4.1.1.8 and 3-4.3.1. Maintenance shall be performed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems NFPA 110 1999 edition 6-4.1 Level 1 and Level 2 EPSSs, including all appurtenant components, shall be inspected weekly and shall be exercised under load at least monthly.	K 144		

TAG #: K-046, MM309

1. Corrective action for the identified problem.
The testing on the emergency lighting for the Aspen CSU had been completed monthly but the testing log was included with the monthly generator test log (see attached).

2. Discipline responsible for monitoring system changes for maintenance of compliance.
- ***Electrician***
- ***M&O Supervisor***

3. Date when correction action will be corrected (usually within 60 days):

Done

TAG #: K-062, MM309

1. Corrective action for the identified problem.
The Aspen CSU sprinkler system has been inspected and tested. A quarterly schedule will be developed to ensure that compliance is maintained.

3. Discipline responsible for monitoring system changes for maintenance of compliance.
- ***Plumber***
- ***M&O Supervisor***

3. Date when correction action will be corrected (usually within 60 days):

April 30, 2010

TAG #: K-144, MM309

1. Corrective action for the identified problem.
Weekly inspections for the Aspen CSU building generator have been initiated and a schedule will be developed to ensure compliance is maintained.

4. Discipline responsible for monitoring system changes for maintenance of compliance.
- ***Electrician***
- ***M&O Supervisor***

3. Date when correction action will be corrected (usually within 60 days):

April 30, 2010

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 03 B. WING _____	03/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 000	16.03.11 Inital Comments The "Aspen" building is a single story structure, with a mechanical loft, that was completed /occupied in December 2002. The building's construction classification is Type V(III) protected wood frame. The building is protected throughout by an automatic fire extinguishing system and a fire alarm/smoke detection system. Emergency power is supplied by an on site, fuel fired, automatic generator as well as battery pack emergency lighting. The building consists of a central core and two wings with sleeping rooms. There is a total of six exits to grade, two in each of the wings containing resident sleeping rooms and two from the central core. The building is divided into three smoke zones by two smoke barrier partition walls. The building has 20 ICF/MR beds. The following deficiencies were cited during the annual Fire/Life Safety survey conducted between March 9, 2010 and March 16, 2010. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, CH 19 Existing Health Care Occupancy and in accordance with IDAPA 16.03.11 - Rules Governing Intermediate Care Facilities For The Mentally Retarded (ICF/MR) The surveyor conducting the fire/life safety survey was: Taylor Barkley Health Facility Surveyor Facility Fire Safety and Construction Program	M 000	RECEIVED APR 0 1 2010 FACILITY STANDARDS	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
SBuetje 3/30/10		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 03 B. WING _____	03/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 000	Continued From Page 1	M 000		
MM309	16.03.11.110 Fire and Life Safety Standards Buildings on the premises used as facilities must meet all the requirements of local, state and national codes concerning fire and life safety standards that are applicable to ICF/MR facilities. This Rule is not met as evidenced by: Refer to federal deficiencies listed on the CMS 2567 form. 1. K046 Testing of Emergency Lighting. 2. K062 Quarterly Sprinkler Inspections 3. K144 Generator Inspections and Checks	MM309	See POC on CMS 2567	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 04 B. WING _____	03/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

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K 000	INITIAL COMMENTS	K 000		

The "Birch" building is a single story structure, with a mechanical loft, that was completed/occupied in December 2002. The building's construction classification is Type V(III) protected wood frame. The building is protected throughout by an automatic fire extinguishing system and fire/ smoke detection system. Emergency power is supplied by an on site, fuel fired, automatic generator as well as battery pack emergency lighting. The building consists of of a central core and two wings with sleeping rooms. There is a total of six exits to grade, two in each of the wings containing sleeping rooms and two from the central core. The building is divided into three smoke zones by two smoke barrier partition walls. The building is licensed for 20 ICF/MR beds.

The following deficiencies were cited during the annual Fire/Life Safety survey conducted between March 9, 2010 and March 16, 2010. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, CH 19 Existing Health Care Occupancy and in accordance with 42 CFR 483.70.

The surveyor conducting the fire/life safety survey was:

Taylor Barkley
Health Facility Surveyor
Facility Fire Safety and Construction Program

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

SBroetje 3/30/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 04 B. WING _____	03/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	Continued From page 1	K 000		
K 046	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This Standard is not met as evidenced by: Based on record review, it was determined the facility had not ensured emergency lighting was being tested monthly or annually. The facility had a census of sixty eight clients on the day of the survey. Findings include: During record review on March 10, 2010 at 11:11 AM, maintenance records revealed the facility did not have records for either monthly or annual testing of the emergency lighting units throughout the facility. This was noted by the Surveyor and the Maintenance Supervisor. This deficiency has the potential to affect eleven clients and all staff present on the day of the survey.	K 046		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 04 B. WING _____	03/16/2010

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K 046	Continued From page 2 Actual Code Reference NFPA 101 - 2000 Edition Chapter 19 Existing Healthcare Occupancies 19.2.9 Emergency Lighting. 19.2.9.1 Emergency lighting shall be provided in accordance with Section 7.9. 7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 11/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction.	K 046		4-30-10 TB
K 062	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5	K 062		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 04 B. WING _____	03/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 062	Continued From page 3 This Standard is not met as evidenced by: Based on record review, the facility failed to inspect and test the automatic sprinkler system as required. The facility had a census of sixty eight clients on the day of the survey. Findings include: Record review on March 10, 2010 between the hours of 10:10 AM and 11:20 AM, revealed that the facility was unable to provide documentation of any quarterly inspections or tests of the automatic sprinkler system. This was noted by the Surveyor and the Maintenance Supervisor. This deficiency has the potential to affect eleven clients and all staff present on the day of the survey. Actual Code Reference NFPA 101 - 2000 Edition Chapter 19 Existing Healthcare Occupancies 19.3.5 Extinguishment Requirements. 19.3.5.1 Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. 9.7.5 Maintenance and Testing. All automatic sprinkler and standpipe systems required by this Code shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems.	K 062		4-30-10 TB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 04 B. WING _____	03/16/2010

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K 062	Continued From page 4 NFPA 25 2-1 General. This chapter provides the minimum requirements for the routine inspection, testing, and maintenance of sprinkler systems. Table 2-1 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance. Table 2-1 Summary of Sprinkler System Inspection, Testing, and Maintenance Quarterly testing for Alarm Devices and Main Drain.	K 062		
K 144	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This Standard is not met as evidenced by: Based on record review, it was determined the facility had not ensured that the emergency generator was being inspected weekly in	K 144		4-30-10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 04 B. WING _____	03/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 144	Continued From page 5 accordance with NFPA 99. The facility had a census of sixty eight clients on the day of the survey. The findings include: Record review of the generator log on March 10, 2010 at 12:37 PM, disclosed that the facility did not document weekly checks on the emergency generator. This was noted by the Surveyor and the Maintenance Supervisor. This deficiency has the potential to affected eleven clients and all staff present on the day of the survey. Actual NFPA standard: NFPA 99 1999 edition 3-4.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches. (a) Maintenance of Alternate Power Source. The generator set or other alternate power source and associated equipment, including all appurtenant parts, shall be so maintained as to be capable of supplying service within the shortest time practicable and within the 10-second interval specified in 3-4.1.1.8 and 3-4.3.1. Maintenance shall be performed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems NFPA 110 1999 edition 6-4.1 Level 1 and Level 2 EPSSs, including all appurtenant components, shall be inspected weekly and shall be exercised under load at least monthly.	K 144		

TAG #: K-046, MM309

1. Corrective action for the identified problem.
The testing on the emergency lighting for the Birch CSU had been completed monthly but the testing log was included with the monthly generator test log (see attached).

2. Discipline responsible for monitoring system changes for maintenance of compliance.
- ***Electrician***
- ***M&O Supervisor***

3. Date when correction action will be corrected (usually within 60 days):

Done

TAG #: K-062, MM309

1. Corrective action for the identified problem.
The Birch CSU sprinkler system has been inspected and tested. A quarterly schedule will be developed to ensure that compliance is maintained.

3. Discipline responsible for monitoring system changes for maintenance of compliance.
- ***Plumber***
- ***M&O Supervisor***

3. Date when correction action will be corrected (usually within 60 days):

April 30, 2010

TAG #: K-144, MM309

1. Corrective action for the identified problem.
Weekly inspections for the Birch CSU building generator have been initiated and a schedule will be developed to ensure compliance is maintained.

4. Discipline responsible for monitoring system changes for maintenance of compliance.
- ***Electrician***
- ***M&O Supervisor***

3. Date when correction action will be corrected (usually within 60 days):

April 30, 2010

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 04 B. WING _____	03/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 000	16.03.11 Inital Comments The "Birch" building is a single story structure, with a mechanical loft, that was completed/occupied in December 2002. The building's construction classification is Type V(III) protected wood frame. The building is protected throughout by an automatic fire extinguishing system and fire/ smoke detection system. Emergency power is supplied by an on site, fuel fired, automatic generator as well as battery pack emergency lighting. The building consists of of a central core and two wings with sleeping rooms. There is a total of six exits to grade, two in each of the wings containing sleeping rooms and two from the central core. The building is divided into three smoke zones by two smoke barrier partition walls. The building is licensed for 20 ICF/MR beds. The following deficiencies were cited during the annual Fire/Life Safety survey conducted between March 9, 2010 and March 16, 2010. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, CH 19 Existing Health Care Occupancy and in accordance with IDAPA 16.03.11 - Rules Governing Intermediate Care Facilities For The Mentally Retarded (ICF/MR) The surveyor conducting the fire/life safety survey was: Taylor Barkley Health Facility Surveyor Facility Fire Safety and Construction Program	M 000	RECEIVED APR 0 1 2010 FACILITY STANDARDS	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 04 B. WING _____	03/16/2010

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M 000	Continued From Page 1	M 000		
MM309	16.03.11.110 Fire and Life Safety Standards Buildings on the premises used as facilities must meet all the requirements of local, state and national codes concerning fire and life safety standards that are applicable to ICF/MR facilities. This Rule is not met as evidenced by: Refer to federal deficiencies listed on the CMS 2567 form. 1. K046 Testing of Emergency Lighting. 2. K062 Quarterly Sprinkler Inspections 3. K144 Generator Inspections and Checks	MM309	See Poc on CMS 2567.	4-30-10 TB

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 05 B. WING _____	03/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS	K 000		

The "Pine" building is a single story structure with a mechanical loft, that was completed/occupied in December of 2002. The building's construction classification is Type V(111) protected wood frame. The building is protected throughout by an automatic fire extinguishing system and a fire alarm/smoke detection system. Emergency power is supplied by an on-site, fuel fired, automatic generator as well as some battery pack emergency lighting. The building consists of a central core and two wings with sleeping rooms. There is a total of six exits to grade, two in each of the wings containing sleeping rooms and two from the central core. The building is divided into three smoke zones by two smoke barrier partition walls. This building has 20 ICF/MR beds.

The following deficiencies were cited during the annual Fire/Life Safety survey conducted between March 9, 2010 and March 16, 2010. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, CH 19 Existing Health Care Occupancy and in accordance with 42 CFR 483.70.

The surveyor conducting the fire/life safety survey was:

Taylor Barkley
Health Facility Surveyor
Facility Fire Safety and Construction Program

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Sbroetje 3/30/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 05 B. WING _____	03/16/2010

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IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1	K 000		
K 046	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This Standard is not met as evidenced by: Based on record review, it was determined the facility had not ensured emergency lighting was being tested monthly or annually. The facility had a census of sixty eight clients on the day of the survey. Findings include: During record review on March 10, 2010 at 11:12 AM, maintenance records revealed the facility did not have records for either monthly or annual testing of the emergency lighting units throughout the facility. This was noted by the Surveyor and the Maintenance Supervisor. This deficiency has the potential to affect seventeen clients and all staff present on the day of the survey.	K 046		4-30-10 TB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 05 B. WING	03/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 046	Continued From page 2 Actual Code Reference NFPA 101 - 2000 Edition Chapter 19 Existing Healthcare Occupancies 19.2.9 Emergency Lighting. 19.2.9.1 Emergency lighting shall be provided in accordance with Section 7.9. 7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 11/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction.	K 046		
K 062	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5	K 062		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 05 B. WING	03/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 062	Continued From page 3 This Standard is not met as evidenced by: Based on record review, the facility failed to inspect and test the automatic sprinkler system as required. The facility had a census of sixty eight clients on the day of the survey. Findings include: Record review on March 10, 2010 between the hours of 10:10 AM and 11:20 AM, revealed that the facility was unable to provide documentation of any quarterly inspections or tests of the automatic sprinkler system. This was noted by the Surveyor and the Maintenance Supervisor. This deficiency has the potential to affect seventeen clients and all staff present on the day of the survey. Actual Code Reference NFPA 101 - 2000 Edition Chapter 19 Existing Healthcare Occupancies 19.3.5 Extinguishment Requirements. 19.3.5.1 Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. 9.7.5 Maintenance and Testing. All automatic sprinkler and standpipe systems required by this Code shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems.	K 062		4-30-10 TR

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 05 B. WING _____	03/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 062	Continued From page 4 NFPA 25 2-1 General. This chapter provides the minimum requirements for the routine inspection, testing, and maintenance of sprinkler systems. Table 2-1 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance. Table 2-1 Summary of Sprinkler System Inspection, Testing, and Maintenance Quarterly testing for Alarm Devices and Main Drain.	K 062		
K 144	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This Standard is not met as evidenced by: Based on record review, it was determined the facility had not ensured that the emergency generator was being inspected weekly in	K 144		4-30-10 TB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 05 B. WING _____	03/16/2010

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K 144	Continued From page 5 accordance with NFPA 99. The facility had a census of sixty eight clients on the day of the survey. The findings include: Record review of the generator log on March 10, 2010 at 12:38 PM, disclosed that the facility did not document weekly checks on the emergency generator. This was noted by the Surveyor and the Maintenance Supervisor. This deficiency has the potential to affect seventeen clients and all staff present on the day of the survey. Actual NFPA standard: NFPA 99 1999 edition 3-4.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches. (a) Maintenance of Alternate Power Source. The generator set or other alternate power source and associated equipment, including all appurtenant parts, shall be so maintained as to be capable of supplying service within the shortest time practicable and within the 10-second interval specified in 3-4.1.1.8 and 3-4.3.1. Maintenance shall be performed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems NFPA 110 1999 edition 6-4.1 Level 1 and Level 2 EPSSs, including all appurtenant components, shall be inspected weekly and shall be exercised under load at least monthly.	K 144		

TAG #: K-046, MM309

1. Corrective action for the identified problem.
The testing on the emergency lighting for the Pine CSU had been completed monthly but the testing log was included with the monthly generator test log (see attached).

2. Discipline responsible for monitoring system changes for maintenance of compliance.
- ***Electrician***
- ***M&O Supervisor***

3. Date when correction action will be corrected (usually within 60 days):

Done

TAG #: K-062, MM309

1. Corrective action for the identified problem.
The Pine CSU sprinkler system has been inspected and tested. A quarterly schedule will be developed to ensure that compliance is maintained.

3. Discipline responsible for monitoring system changes for maintenance of compliance.
- ***Plumber***
- ***M&O Supervisor***

3. Date when correction action will be corrected (usually within 60 days):

April 30, 2010

TAG #: K-144, MM309

1. Corrective action for the identified problem.
Weekly inspections for the Pine CSU building generator have been initiated and a schedule will be developed to ensure compliance is maintained.

4. Discipline responsible for monitoring system changes for maintenance of compliance.
- ***Electrician***
- ***M&O Supervisor***

3. Date when correction action will be corrected (usually within 60 days):

April 30, 2010

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 05 B. WING _____	03/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 000	16.03.11 Inital Comments The "Pine" building is a single story structure with a mechanical loft, that was completed/occupied in December of 2002. The building's construction classification is Type V(111) protected wood frame. The building is protected throughout by an automatic fire extinguishing system and a fire alarm/smoke detection system. Emergency power is supplied by an on-site, fuel fired, automatic generator as well as some battery pack emergency lighting. The building consists of a central core and two wings with sleeping rooms. There is a total of six exits to grade, two in each of the wings containing sleeping rooms and two from the central core. The building is divided into three smoke zones by two smoke barrier partition walls. This building has 20 ICF/MR beds. The following deficiencies were cited during the annual Fire/Life Safety survey conducted between March 9, 2010 and March 16, 2010. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, CH 19 Existing Health Care Occupancy and in accordance with IDAPA 16.03.11 - Rules Governing Intermediate Care Facilities For The Mentally Retarded (ICF/MR) The surveyor conducting the fire/life safety survey was: Taylor Barkley Health Facility Surveyor Facility Fire Safety and Construction Program	M 000	RECEIVED APR 0 1 2010 FACILITY STANDARDS	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

SBroetje 3/30/10

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 05 B. WING _____	03/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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M 000	Continued From Page 1	M 000		
MM309	16.03.11.110 Fire and Life Safety Standards Buildings on the premises used as facilities must meet all the requirements of local, state and national codes concerning fire and life safety standards that are applicable to ICF/MR facilities. This Rule is not met as evidenced by: Refer to federal deficiencies listed on the CMS 2567 form. 1. K046 Testing of Emergency Lighting. 2. K062 Quarterly Sprinkler Inspections 3. K144 Generator Inspections and Checks	MM309	See Poc on 2567	4-30-10

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 06 B. WING _____	03/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS	K 000		

The Birch Mini Gym #1 is the multi-purpose building constructed in November 2002 as an unattached Type V(III) building. The structure is used for sports activities and is principally equipped with a basketball floor and hoops. There is a fire alarm system installed in the building and exiting classification is remote capability. Battery pack emergency lighting is provided.

The following deficiencies were cited during the annual Fire/Life Safety survey conducted between March 9, 2010 and March 16, 2010. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition and in accordance with 42 CFR 483.70.

The surveyor conducting the fire/life safety survey was:

Taylor Barkley
Health Facility Surveyor
Facility Fire Safety and Construction Program

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

JBoetje 3/30/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 06 B. WING _____	03/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	Continued From page 1	K 000		
K 130	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This Standard is not met as evidenced by: 1. Based on record review, it was determined the facility had not ensured emergency lighting was being tested monthly or annually. The facility had a census of sixty eight clients on the day of the survey. Findings include: During record review on March 10, 2010 at 12:55 PM, maintenance records revealed the facility did not have records for either monthly or annual testing of the emergency lighting units throughout the facility. This was noted by the Surveyor and the Maintenance Supervisor. This deficiency has the potential to affect seven clients and all staff present on the day of the survey. 2. Based on record review, it was determined the facility had not ensured that the fire alarm was being inspected annually. The facility had a census of sixty eight clients on the day of the survey. Findings include: During record review on March 10, 2010 at 10:10 AM, maintenance records revealed the facility did not have records for annual testing of the fire alarm system for the facility. This was noted by	K 130		4-30-10 TB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 06 B. WING _____	03/16/2010

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K 130	Continued From page 2 the Surveyor and the Maintenance Supervisor. This deficiency has the potential to affect seven clients and all staff present on the day of the survey. Actual Code Reference NFPA 101 2000 Edition 4.6.12.2 Existing life safety features obvious to the public, if not required by the Code, shall be either maintained or removed.	K 130		

TAG #: K-130, MM309
Citation #1

1. Corrective action for the identified problem.
The emergency lighting system for the Birch Mini Gym #2 has been tested. A schedule is being developed to ensure the continued compliance with monthly inspections.

2. Discipline responsible for monitoring system changes for maintenance of compliance.
- ***Electrician***
- ***M&O Supervisor***

3. Date when correction action will be corrected (usually within 60 days):

April 30, 2010

TAG #: K-130, MM309
Citation #2

1. Corrective action for the identified problem.
The Birch Mini Gym fire alarm system has been inspected at the same time Birch CSU was inspected. However, the inspector did not differentiate the two buildings on the report. This will be requested at the time of the next inspection. A schedule for monthly and annual inspections will be developed to ensure that compliance is maintained.

3. Discipline responsible for monitoring system changes for maintenance of compliance.
- ***Plumber***
- ***M&O Supervisor***

3. Date when correction action will be corrected (usually within 60 days):

April 30, 2010

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 06 B. WING _____	03/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

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M 000	16.03.11 Inital Comments The Birch Mini Gym #1 is the multi-purpose building constructed in November 2002 as an unattached Type V(III) building. The structure is used for sports activities and is principally equipped with a basketball floor and hoops. There is a fire alarm system installed in the building and exiting classification is remote capability. Battery pack emergency lighting is provided. The following deficiencies were cited during the annual Fire/Life Safety survey conducted between March 9, 2010 and March 16, 2010. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition and in accordance with IDAPA 16.03.11 - Rules Governing Intermediate Care Facilities For The Mentally Retarded (ICF/MR) The surveyor conducting the fire/life safety survey was: Taylor Barkley Health Facility Surveyor Facility Fire Safety and Construction Program	M 000	RECEIVED APR 0 1 2010 FACILITY STANDARDS	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

DBroetje 3/30/10

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 06 B. WING _____	03/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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M 000	Continued From Page 1	M 000		
MM309	16.03.11.110 Fire and Life Safety Standards Buildings on the premises used as facilities must meet all the requirements of local, state and national codes concerning fire and life safety standards that are applicable to ICF/MR facilities. This Rule is not met as evidenced by: Refer to federal deficiencies listed on the CMS 2567 form. 1. K130 Testing of Emergency Lighting. 2. K130 Annual Fire Alarm Inspection	MM309	See Poc on CMS 2567	4-30-10

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 07 B. WING _____	03/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS	K 000		

The Aspen Mini Gym #2 is the multi-purpose building constructed in November 2002 as an unattached Type V(III) building. The structure is used for sports activities and is principally equipped with a basketball floor and hoops. There is a fire alarm system installed in the building and exiting classification is remote capability. Battery pack emergency lighting is provided.

The following deficiencies were cited during the annual Fire/Life Safety survey conducted between March 9, 2010 and March 16, 2010. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition and in accordance with 42 CFR 483.70.

The surveyor conducting the fire/life safety survey was:

Taylor Barkley
Health Facility Surveyor
Facility Fire Safety and Construction Program

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

SBroetje 3/29/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 07 B. WING _____	03/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	Continued From page 1	K 000		
K 130	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This Standard is not met as evidenced by: 1. Based on record review, it was determined the facility had not ensured emergency lighting was being tested monthly or annually. The facility had a census of sixty eight clients on the day of the survey. Findings include: During record review on March 10, 2010 at 12:57 PM, maintenance records revealed the facility did not have records for either monthly or annual testing of the emergency lighting units throughout the facility. This was noted by the Surveyor and the Maintenance Supervisor. This deficiency has the potential to affect seven clients and all staff present on the day of the survey. 2. Based on record review, it was determined the facility had not ensured that the fire alarm was being inspected annually. The facility had a census of sixty eight clients on the day of the survey. Findings include: During record review on March 10, 2010 at 10:12 AM, maintenance records revealed the facility did not have records for annual testing of the fire	K 130		4-30-10 TR

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 07 B. WING _____	03/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

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K 130	Continued From page 2 alarm system for the facility. This was noted by the Surveyor and the Maintenance Supervisor. This deficiency has the potential to affect seven clients and all staff present on the day of the survey. Actual Code Reference NFPA 101 2000 Edition 4.6.12.2 Existing life safety features obvious to the public, if not required by the Code, shall be either maintained or removed.	K 130		

TAG #: K-130, MM309
Citation #1

1. Corrective action for the identified problem.
The emergency lighting system for the Aspen Mini Gym #2 has been tested. A schedule is being developed to ensure the continued compliance with monthly inspections.

2. Discipline responsible for monitoring system changes for maintenance of compliance.
- ***Electrician***
- ***M&O Supervisor***

3. Date when correction action will be corrected (usually within 60 days):

April 30, 2010

TAG #: K-130, MM309
Citation #2

1. Corrective action for the identified problem.
The Aspen Mini Gym fire alarm system has been inspected at the same time Aspen CSU was inspected. However, the inspector did not differentiate the two buildings on the report. This will be requested at the time of the next inspection. A schedule for monthly and annual inspections will be developed to ensure that compliance is maintained.

3. Discipline responsible for monitoring system changes for maintenance of compliance.
- ***Plumber***
- ***M&O Supervisor***

3. Date when correction action will be corrected (usually within 60 days):

April 30, 2010

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 07 B. WING _____	03/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 000	16.03.11 Inital Comments The Aspen Mini Gym #2 is the multi-purpose building constructed in November 2002 as an unattached Type V(III) building. The structure is used for sports activities and is principally equipped with a basketball floor and hoops. There is a fire alarm system installed in the building and exiting classification is remote capability. Battery pack emergency lighting is provided. The following deficiencies were cited during the annual Fire/Life Safety survey conducted between March 9, 2010 and March 16, 2010. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition and in accordance with IDAPA 16.03.11 - Rules Governing Intermediate Care Facilities For The Mentally Retarded (ICF/MR) The surveyor conducting the fire/life safety survey was: Taylor Barkley Health Facility Surveyor Facility Fire Safety and Construction Program	M 000	RECEIVED APR 0 1 2010 FACILITY STANDARDS	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

SBroetje 3/29/10

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 07 B. WING _____	03/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 000	Continued From Page 1	M 000		
MM309	16.03.11.110 Fire and Life Safety Standards Buildings on the premises used as facilities must meet all the requirements of local, state and national codes concerning fire and life safety standards that are applicable to ICF/MR facilities. This Rule is not met as evidenced by: Refer to federal deficiencies listed on the CMS 2567 form. 1. K130 Testing of Emergency Lighting. 2. K130 Annual Fire Alarm Inspection	MM309	See Poc on CMS 2567	4-30-10

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 08 B. WING _____	03/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS The structure was built in January 1945 and serves as an auto repair shop. The following deficiencies were cited during the annual Fire/Life Safety survey conducted between March 9, 2010 and March 16, 2010. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition and in accordance with 42 CFR 483.70. The surveyor conducting the fire/life safety survey was: Taylor Barkley Health Facility Surveyor Facility Fire Safety and Construction Program	K 000	RECEIVED APR 0 1 2010 FACILITY STANDARDS	
K 130	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786	K 130		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

SBroetje 3/29/10

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 08 B. WING _____	03/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 130	Continued From page 1 This Standard is not met as evidenced by: Based on record review, it was determined the facility had not ensured emergency lighting was being tested monthly or annually. The facility had a census of sixty eight clients on the day of the survey. Findings include: During record review on March 10, 2010 at 11:14 AM, maintenance records revealed the facility did not have records for either monthly or annual testing of the emergency lighting units throughout the facility. This was noted by the Surveyor and the Maintenance Supervisor. This deficiency has the potential to affect five clients and all staff present on the day of the survey. Actual Code Reference NFPA 101 - 2000 Edition Chapter 40 Industrial Occupancies 40.2.9* Emergency Lighting. Emergency lighting shall be provided in accordance with Section 7.9.	K 130		4-30-10 TB

TAG #: K-130
Citation #1

1. Corrective action for the identified problem.
Emergency lights in the auto repair shop have been repaired and were tested on 3/27/10. A monthly inspection schedule will be developed to ensure continued compliance.

2. Discipline responsible for monitoring system changes for maintenance of compliance.
- ***Electrician***
- ***M&O Supervisor***

3. Date when correction action will be corrected (usually within 60 days):

April 30, 2010

TAG #: MM-345
Citation #1

1. Corrective action for the identified problem.
The fire extinguisher in the auto repair shop has been inspected. A monthly inspection schedule will be developed to ensure continued compliance.

3. Discipline responsible for monitoring system changes for maintenance of compliance.
- ***DDTL***
- ***M&O Supervisor***

3. Date when correction action will be corrected (usually within 60 days):

April 30,2010

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 08 B. WING _____	03/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 000	16.03.11 Inital Comments The structure was built in January 1945 and serves as an auto repair shop. The following deficiencies were cited during the annual Fire/Life Safety survey conducted between March 9, 2010 and March 16, 2010. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition and in accordance with IDAPA 16.03.11 - Rules Governing Intermediate Care Facilities For The Mentally Retarded (ICF/MR) The surveyor conducting the fire/life safety survey was: Taylor Barkley Health Facility Surveyor Facility Fire Safety and Construction Program	M 000	RECEIVED APR 0 1 2010 FACILITY STANDARDS	
MM345	16.03.11.110.06(f) Portable Fire Extinguishers Portable fire extinguishers must be serviced in accordance with the applicable NFPA Standard 10 (1978 edition), "Portable Fire Extinguishers."	MM345		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
SBroetje		3/29/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 08 B. WING _____	03/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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MM345	Continued From Page 1 This Rule is not met as evidenced by: Based on observation the facility did not ensure that portable fire extinguishers were being checked on a monthly basis. The facility had a census of sixty eight clients on the day of the survey. Findings include: During the tour of the facility on March 9, 2010 at 9:05 AM, observation of the portable fire extinguishers revealed that they were not being checked on a monthly basis or being signed off on the affixed tag. This was observed by the Surveyor and the Maintenance Supervisor. This deficiency has the potential to affect five clients and all staff present on the day of the survey. NFPA 10 4-3 Inspection. 4-3.1* Frequency. Fire extinguishers shall be inspected when initially placed in service and thereafter at approximately 30-day intervals. Fire extinguishers shall be inspected at more frequent intervals when circumstances require.	MM345		4-30-10 TB

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 09 B. WING _____	03/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS The structure was built in January 1954 and serves as an auto detail shop. The following deficiencies were cited during the annual Fire/Life Safety survey conducted between March 9, 2010 and March 16, 2010. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition and in accordance with 42 CFR 483.70. The surveyor conducting the fire/life safety survey was: Taylor Barkley Health Facility Surveyor Facility Fire Safety and Construction Program	K 000	RECEIVED APR 0 1 2010 FACILITY STANDARDS	
K 130	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786	K 130		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

SBroetje 3/29/10

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 09 B. WING _____	03/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 130	Continued From page 1 This Standard is not met as evidenced by: Based on record review, it was determined the facility had not ensured emergency lighting was being tested monthly or annually. The facility had a census of sixty eight clients on the day of the survey. Findings include: During record review on March 10, 2010 at 11:15 AM, maintenance records revealed the facility did not have records for either monthly or annual testing of the emergency lighting units throughout the facility. This was noted by the Surveyor and the Maintenance Supervisor. This deficiency has the potential to affect three clients and all staff present on the day of the survey. Actual Code Reference NFPA 101 - 2000 Edition Chapter 40 Industrial Occupancies 40.2.9* Emergency Lighting. Emergency lighting shall be provided in accordance with Section 7.9.	K 130		4-30-10 TS

TAG #: K-130
Citation #1

1. Corrective action for the identified problem.
Emergency lights in the auto detail shop have been repaired. A monthly inspection schedule will be developed to ensure they continue to be operable.

2. Discipline responsible for monitoring system changes for maintenance of compliance.
- ***Electrician***
- ***M&O Supervisor***

3. Date when correction action will be corrected (usually within 60 days):

April 30, 2010

TAG #: MM-345
Citation #1

1. Corrective action for the identified problem.
The fire extinguisher has been inspected. A monthly inspection schedule will be developed to ensure continued compliance.

3. Discipline responsible for monitoring system changes for maintenance of compliance.
- ***DDTL***
- ***M&O Supervisor***

3. Date when correction action will be corrected (usually within 60 days):

April 30,2010

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 09 B. WING _____	03/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

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M 000	16.03.11 Inital Comments The structure was built in January 1954 and serves as an auto detail shop. The following deficiencies were cited during the annual Fire/Life Safety survey conducted between March 9, 2010 and March 16, 2010. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition and in accordance with IDAPA 16.03.11 - Rules Governing Intermediate Care Facilities For The Mentally Retarded (ICF/MR) The surveyor conducting the fire/life safety survey was: Taylor Barkley Health Facility Surveyor Facility Fire Safety and Construction Program	M 000	RECEIVED APR 01 2010 FACILITY STANDARDS	
MM345	16.03.11.110.06(f) Portable Fire Extinguishers Portable fire extinguishers must be serviced in accordance with the applicable NFPA Standard 10 (1978 edition), "Portable Fire Extinguishers."	MM345		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

SBroetje 3/29/10

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 09 B. WING _____	03/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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MM345	Continued From Page 1 This Rule is not met as evidenced by: Based on observation the facility did not ensure that portable fire extinguishers were being checked on a monthly basis. The facility had a census of sixty eight clients on the day of the survey. Findings include: During the tour of the facility on March 9, 2010 at 9:02 AM, observation of the portable fire extinguishers revealed that they were not being checked on a monthly basis or being signed off on the affixed tag. This was observed by the Surveyor and the Maintenance Supervisor. This deficiency has the potential to affect three clients and all staff present on the day of the survey. NFPA 10 4-3 Inspection. 4-3.1* Frequency. Fire extinguishers shall be inspected when initially placed in service and thereafter at approximately 30-day intervals. Fire extinguishers shall be inspected at more frequent intervals when circumstances require.	MM345		4-30-10

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 10 B. WING _____	03/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS The structure was built in January 1944 and serves as the central laundry. The following deficiencies were cited during the annual Fire/Life Safety survey conducted between March 9, 2010 and March 16, 2010. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition and in accordance with 42 CFR 483.70. The surveyor conducting the fire/life safety survey was: Taylor Barkley Health Facility Surveyor Facility Fire Safety and Construction Program	K 000	RECEIVED APR 01 2010 FACILITY STANDARDS	
K 130	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786	K 130		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

SBroetje 3/29/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 10 B. WING _____	03/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

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K 130	Continued From page 1 This Standard is not met as evidenced by: Based on record review, the facility failed to inspect and test the automatic sprinkler system as required. The facility had a census of sixty eight clients on the day of the survey. Findings include: Record review on March 10, 2010 between the hours of 10:10 AM and 11:20 AM, revealed that the facility was unable to provide documentation of any annual tests of the automatic sprinkler system. This was noted by the Surveyor and the Maintenance Supervisor. This deficiency has the potential to affect five clients and all staff present on the day of the survey. Actual Code Reference NFPA 101 2000 Edition 4.6.12.2 Existing life safety features obvious to the public, if not required by the Code, shall be either maintained or removed.	K 130		4-30-10 TB

TAG #: K-130
Citation #1

1. Corrective action for the identified problem.
An inspection of the laundry sprinkler system has be completed and an annual inspection will be completed

2. Discipline responsible for monitoring system changes for maintenance of compliance.
- ***Plumber***
- ***M&O Supervisor***

3. Date when correction action will be corrected (usually within 60 days):

April 30, 2010

TAG #: MM-345
Citation #1

1. Corrective action for the identified problem.
The fire extinguisher has been checked and a monthly schedule will be developed.

3. Discipline responsible for monitoring system changes for maintenance of compliance.
- ***Laundry Lead Worker***
- ***M&O Supervisor***

3. Date when correction action will be corrected (usually within 60 days):

April 30,2010

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 10 B. WING _____	03/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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M 000	16.03.11 Inital Comments The structure was built in January 1944 and serves as the central laundry. The following deficiencies were cited during the annual Fire/Life Safety survey conducted between March 9, 2010 and March 16, 2010. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition and in accordance with IDAPA 16.03.11 - Rules Governing Intermediate Care Facilities For The Mentally Retarded (ICF/MR) The surveyor conducting the fire/life safety survey was: Taylor Barkley Health Facility Surveyor Facility Fire Safety and Construction Program	M 000	RECEIVED APR 0 1 2010 FACILITY STANDARDS	
MM345	16.03.11.110.06(f) Portable Fire Extinguishers Portable fire extinguishers must be serviced in accordance with the applicable NFPA Standard 10 (1978 edition), "Portable Fire Extinguishers."	MM345		4-30-10 TB

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

SBroetje 3/29/10

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 10 B. WING _____	03/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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MM345	Continued From Page 1 This Rule is not met as evidenced by: Based on observation the facility did not ensure that portable fire extinguishers were being checked on a monthly basis. The facility had a census of sixty eight clients on the day of the survey. Findings include: During the tour of the facility on March 9, 2010 at 9:11 AM, observation of the portable fire extinguishers revealed that they were not being checked on a monthly basis or being signed off on the affixed tag. This was observed by the Surveyor and the Maintenance Supervisor. This deficiency has the potential to affect five clients and all staff present on the day of the survey. NFPA 10 4-3 Inspection. 4-3.1* Frequency. Fire extinguishers shall be inspected when initially placed in service and thereafter at approximately 30-day intervals. Fire extinguishers shall be inspected at more frequent intervals when circumstances require.	MM345		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 11 B. WING _____	03/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

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K 000	INITIAL COMMENTS	K 000		

The building was built in January 1984 and is Type V(III) construction. The facility currently uses the unattached building as a therapy pool which makes up 70% of the interior floor space inside. Currently the facility is licensed for 80 ICF/MR beds.

The following deficiencies were cited during the annual Fire/Life Safety survey conducted between March 9, 2010 and March 16, 2010. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition and in accordance with 42 CFR 483.70.

The surveyor conducting the fire/life safety survey was:

Taylor Barkley
Health Facility Surveyor
Facility Fire Safety and Construction Program

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

S Buseltz 3/29/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 11 B. WING _____	03/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 130 K 130	Continued From page 1 NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This Standard is not met as evidenced by: Based on record review, it was determined the facility had not ensured emergency lighting was being tested monthly or annually and was operable.. The facility had a census of sixty eight clients on the day of the survey. Findings include: 1. During record review on March 10, 2010 at 11:13 AM, maintenance records revealed the facility did not have records for either monthly or annual testing of the emergency lighting units throughout the facility. This was noted by the Surveyor and the Maintenance Supervisor. This deficiency has the potential to affect eight clients and all staff present on the day of the survey. 2. During the tour of the facility on March 9, 2010 at 10:58 AM, testing of the emergency lighting unit in the facility revealed that it would not illuminate upon pressing of the test button.. This was noted by the Surveyor and the Maintenance Supervisor. This deficiency has the potential to affect eight clients and all staff present on the day of the survey. Actual Code Reference NFPA 101 - 2000 Edition	K 130 K 130		4-30-10 TB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 11 B. WING _____	03/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

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K 130	Continued From page 2 4.6.12.2 Existing life safety features obvious to the public, if not required by the Code, shall be either maintained or removed.	K 130		

TAG #: K-130 & MM309
Citation #1

1. Corrective action for the identified problem.
Emergency lights for the pool have been repaired and were tested 3/27/10. Emergency lighting is on a monthly inspection.

2. Discipline responsible for monitoring system changes for maintenance of compliance.
- ***Electrician***
- ***M&O Supervisor***

3. Date when correction action will be corrected (usually within 60 days):

March 23, 2010 repaired

April 30,2010

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 11 B. WING _____	03/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 000	16.03.11 Inital Comments The building was built in January 1984 and is Type V(III) construction. The facility currently uses the unattached building as a therapy pool which makes up 70% of the interior floor space inside. Currently the facility is licensed for 80 ICF/MR beds. The following deficiencies were cited during the annual Fire/Life Safety survey conducted between March 9, 2010 and March 16, 2010. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition and in accordance with IDAPA 16.03.11 - Rules Governing Intermediate Care Facilities For The Mentally Retarded (ICF/MR) The surveyor conducting the fire/life safety survey was: Taylor Barkley Health Facility Surveyor Facility Fire Safety and Construction Program	M 000	RECEIVED APR 0 1 2010 FACILITY STANDARDS	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

SBroetje 3/29/10

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 11 B. WING _____	03/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM309	Continued From Page 1	MM309		
MM309	16.03.11.110 Fire and Life Safety Standards Buildings on the premises used as facilities must meet all the requirements of local, state and national codes concerning fire and life safety standards that are applicable to ICF/MR facilities. This Rule is not met as evidenced by: Refer to federal deficiencies listed on the CMS 2567 form. 1. K130 Emergency Lighting	MM309	See PoC on CMS 2567	4-30-10 TB

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 12 B. WING _____	03/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS	K 000		

Ramsey is an unattached single story building and is Type V(III) construction. The building is used as an educational unit/school on campus. There is a fire alarm system installed throughout the building with horn strobe units in classrooms and is off site monitored. Local school district contractors provide services within the building. The building was constructed in 1951 and has a partial basement. Exiting classification is remote capability.

The following deficiencies were cited during the annual Fire/Life Safety survey conducted between March 9, 2010 and March 16, 2010. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition and in accordance with 42 CFR 483.70.

The surveyor conducting the fire/life safety survey was:

Taylor Barkley
Health Facility Surveyor
Facility Fire Safety and Construction Program

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

SBroetje 3/29/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 12 B. WING _____	03/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1	K 000		
K 130	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This Standard is not met as evidenced by: 1. Based on record review, the facility failed to conduct fire drills as required. The facility had a census of sixty eight clients on the day of the survey. Findings include: Record review on March 10, 2010 at 12:42 PM, revealed that the facility was unable to provide documentation for fire drills being conducted at the facility. This was noted by the Surveyor and the Maintenance Supervisor. This deficiency has the potential to affect twenty clients and all staff present on the day of the survey. Actual Code Reference NFPA 101 - 2000 Edition Chapter 15 Existing Educational Occupancies 15.7.1.2 Emergency egress and relocation drills shall be conducted as follows: (1) Not less than one emergency egress and relocation drill shall be conducted every month	K 130		4-30-10 7B

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 12 B. WING _____	03/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 130	Continued From page 2 the facility is in session. Exception: In climates where the weather is severe, the monthly emergency egress and relocation drills shall be permitted to be deferred, provided that the required number of emergency egress and relocation drills is achieved and not less than four are conducted before the drills are deferred. (2) All occupants of the building shall participate in the drill. (3) One additional emergency egress and relocation drill, other than for educational occupancies that are open on a year-round basis, shall be required within the first 30 days of operation. 2. Based on record review and observation, the facility failed to ensure that emergency lights worked and were being maintained. The facility had a census of sixty eight clients on the day of the survey. Findings include: During record review on March 10, 2010 at 11:09 AM, maintenance records revealed the facility did not have records for either monthly or annual testing of the emergency lighting units throughout the facility. This was noted by the Surveyor and the Maintenance Supervisor. This deficiency has the potential to affect twenty clients and all staff present on the day of the survey. During the tour of the facility on March 9, 2010 at 12:55 PM, testing of the emergency lighting unit in the stairwell revealed that it would not illuminate upon pressing of the test button.. This was noted by the Surveyor and the Maintenance Supervisor. This deficiency has the potential to affect twenty clients and all staff present on the	K 130		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 12 B. WING _____	03/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 130	Continued From page 3 day of the survey. Actual Code Reference NFPA 101 - 2000 Edition Chapter 15 Existing Educational Occupancies 15.2.9 Emergency Lighting. Emergency lighting shall be provided in accordance with Section 7.9 in the following areas: (1) Interior stairs and corridors (2) Assembly use spaces (3) Flexible and open plan buildings (4) Interior or windowless portions of buildings (5) Shops and laboratories 7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 11/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction.	K 130		

TAG #: K-130 & MM309
Citation #1

1. Corrective action for the identified problem.
A fire drill was completed in February. Previous requirements were quarterly drills. We have now initiated a monthly fire drill schedule. The local school district no longer uses the building.

2. Discipline responsible for monitoring system changes for maintenance of compliance.
- ***Maintenance Craftsman***
- ***M&O Supervisor***

3. Date when correction action will be corrected (usually within 60 days):

April 30, 2010

TAG #: K-130 & MM309
Citation #2

1. Corrective action for the identified problem.
Emergency lights have been repaired and were tested 3/27/10. Emergency lighting is now on a monthly inspection.

3. Discipline responsible for monitoring system changes for maintenance of compliance.
- ***Electrician***
- ***M&O Supervisor***

3. Date when correction action will be corrected (usually within 60 days):

April 30, 2010

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 12 B. WING _____	03/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO STATE SCHOOL AND HOSPITAL	1660 ELEVENTH AVENUE NORTH NAMPA, ID 83687

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M 000	16.03.11 Inital Comments Ramsey is an unattached single story building and is Type V(III) construction. The building is used as an educational unit/school on campus. There is a fire alarm system installed throughout the building with horn strobe units in classrooms and is off site monitored. Local school district contractors provide services within the building. The building was constructed in 1951 and has a partial basement. Exiting classification is remote capability. The following deficiencies were cited during the annual Fire/Life Safety survey conducted between March 9, 2010 and March 16, 2010. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition and in accordance with IDAPA 16.03.11 - Rules Governing Intermediate Care Facilities For The Mentally Retarded (ICF/MR) The surveyor conducting the fire/life safety survey was: Taylor Barkley Health Facility Surveyor Facility Fire Safety and Construction Program	M 000	RECEIVED APR 0 1 2010 FACILITY STANDARDS	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

SBroetje 3/29/10

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 12 B. WING _____	03/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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M 000	Continued From Page 1	M 000		
MM309	16.03.11.110 Fire and Life Safety Standards Buildings on the premises used as facilities must meet all the requirements of local, state and national codes concerning fire and life safety standards that are applicable to ICF/MR facilities. This Rule is not met as evidenced by: Refer to federal deficiencies listed on the CMS 2567 form. 1. K130 Fire Drills 2. K130 Emergency Lighting.	MM309	See POC on CMS 2567.	4-30-10 TB

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0036
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E-mail: fsb@dhw.idaho.gov

March 22, 2010

Susan Broetje
Idaho State School & Hospital
1660 Eleventh Avenue North
Nampa, ID 83687

RE: Idaho State School & Hospital, provider #13G001

Dear Ms. Broetje:

This is to advise you of the findings of the Medicaid/Licensure Fire Life Safety Survey, which was concluded at Idaho State School & Hospital, on March 16, 2010.

Enclosed is your copy of a Statement of Deficiencies/Plan of Correction, form CMS-2567, which states that no Medicaid deficiencies were noted at the time of the survey for the Chapel. Also, enclosed is a similar form stating that no State licensure deficiencies were noted at the time of the survey.

Thank you for the courtesies extended to us during our visit. If we can be of any help to you, please call our office at (208) 334-6626.

Sincerely,

TAYLOR BARKLEY
Health Facility Surveyor
Facility Fire Safety and Construction Program

TB/lj

Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G001	A. BUILDING 13 B. WING _____	03/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS	K 000		

The Chapel is an unattached building that is Type V(III) construction built in January 1974. The building has a smoke detection system installed. Exiting classification is remote capability.

The facility was found to be in substantial compliance during the annual Fire/Life Safety survey conducted between March 9, 2010 and March 16, 2010. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition and in accordance with 42 CFR 483.70.

The surveyor conducting the fire/life safety survey was:

Taylor Barkley
Health Facility Surveyor
Facility Fire Safety and Construction Program

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

SBurtje 3/29/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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M 000	16.03.11 Inital Comments The Chapel is an unattached building that is Type V(III) construction built in January 1974. The building has a smoke detection system installed. Exiting classification is remote capability. The facility was found to be in substantial compliance during the annual Fire/Life Safety survey conducted between March 9, 2010 and March 16, 2010. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition and in accordance with IDAPA 16.03.11 - Rules Governing Intermediate Care Facilities For The Mentally Retarded (ICF/MR) The surveyor conducting the fire/life safety survey was: Taylor Barkley Health Facility Surveyor Facility Fire Safety and Construction Program	M 000	RECEIVED APR 01 2010 FACILITY STANDARDS	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

SBuetje 3/29/10